XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
DEMOND L. PHILSON
Deputy Attorney General
State Bar No. 220220
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7548
Facsimile: (916) 327-2247
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Chandan Deep Singh Cheema, M.D.** **Capital Medical Extended Care** **3001 Douglas Blvd Ste 325** **Roseville, CA 95661** **Physician's and Surgeon's Certificate No. A 47747,** Respondent.	Case No. 800-2017-032495 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 27, 1989, the Medical Board issued Physician's and Surgeon's Certificate Number A 47747 to Chandan Deep Singh Cheema, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

5. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and treatment of patient A[1]. The circumstances are as follows:

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[1] The patient is referred to by letter in order to preserve privacy. The patient's identity will be disclosed in the discovery provided to the respondent.

Patient A

8. On July 18, 2012 patient A was transferred to Rock Creek Care Center. Patient A was a 44 year-old male with a history of non-specific joint pain, gout, hyperuricemia, and a known history of accidental opiate overdose in October 2011 and a second overdose on methadone on July 3, 2012. Patient A was admitted to the hospital with acute renal failure with hyperkalemia, benign prostatic hyperplasia (BPH)[2], and elevated liver enzymes. Patient A was admitted to Rock Creek Care Center by Dr. J.V. who continued his methadone, hydromorphone and hydrocodone with acetaminophen as per the discharge summary from Sutter Auburn Faith Hospital.

9. On the next day, July 19, 2018, a nurse practitioner saw patient A because patient A felt that the pain was not controlled. The nurse practitioner changed the hydromorphone from an as needed basis to routine and increased the Norco from 5/325 to 10/325 1-2 tablets every 4 hours as needed.

10. Patient A was seen and examined primarily by the nurse practitioners though references were made that psychiatrist saw the patient for pain management. Patient A was seen by a podiatrist as a courtesy since podiatry care was not reimbursed by his Medi-Cal insurance. Patient A was also seen by an optometrist and dentist. References in the medical notes were made that patient A was to be seen by a rheumatologist but it is unknown whether the patient was seen by one.

11. On July 27, 2012, the Respondent's first signature was on Patient A's record when he signed the Refill Authorization Request for hydromorphone. Patient A had been admitted to the Rock Creek Care Center nine days earlier by Dr. J.V. The admission history and physical by Dr. J.V. was completed by the time Respondent signed the Refill Authorization Request. There was no accompanying note documenting the first episode of Respondent's refilling of hydrocodone. Although the attending physician of record was Dr. J.V., the Respondent signed 16 prescriptions

[2] Benign prostatic hyperplasia (BPH) — also called prostate gland enlargement — is a common condition as men get older. An enlarged prostate gland can cause uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. It can also cause bladder, urinary tract or kidney problems.

for the controlled substances while the patient was at Rock Creek Care Center for a total of 229 days.

12. On November 6, 2012, Patient A was seen by Respondent for treatment. This was approximately 103 days after patient A's July 27, 2012, visit. Respondent co-signed the nurse practitioner's note and added "See pt every 2 months for f/u." By this time, Respondent had already signed 9 prescriptions. Respondent had developed and established a duty to the patient. Since the Respondent indicated that the patient should now be seen every 2 months, he made a clinical judgment. Respondent was aware of Patient A's indication for the admission to Rock Creek Care Center and was also aware it was for "rehabilitation and continuation of care" on September 25, 2012, and "Continue medication as directed from the hospital discharge summary" on July 18, 2012, as indicated in patient A's medical notes. Respondent also had knowledge of patient A's two episodes of overdose within the last year as indicated in his medical notes.

13. Between July 27, 2012, and February 27, 2013, Respondent was the only physician who signed multiple prescriptions for Hydromorphone[3], Methadone[4], and Dilaudid without documenting what information he relied upon to justify the continuation of the controlled substances. Respondent continued the prescription of the controlled substances without considering adjustments to lower the dosages. Since Respondent developed and established a duty to this patient and had reasonable information available to adjust the level of physician or nurse practitioner care (or frequency of visits), he also had reasonable information available to proactively reduce the dose, frequency and type of narcotics prescribed in this patient with known multiple narcotic overdoses.

14. Between July 27, 2012, and February 27, 2013, Respondent was the only physician who signed multiple prescriptions for high doses of Hydromorphone, Methadone, and Dilaudid

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[3] Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

without documenting what information he relied upon to justify the continuation of the controlled substances.

15. In February 2013, a month prior to patient A's discharge from Rock Creek Care Center, he was referred to a pain specialist at UC Davis Pain Service, but they could not accommodate the referral.

16. On March 4, 2013, patient A was discharged from Rock Creek Care Center. Patient A was supposed to follow up with his primary care physician Dr. P.C. after he was discharged. There are no copies of medical records available reflecting patient A's care after he was discharged. However, according to available CURES reports, patient A was prescribed lower doses of Norco and had 2 prescriptions of Percocet 5/325 by a variety of prescribers. Patient A's first prescription by Dr. P.C. was September 2013. There were no prescriptions for methadone in patient A's CURES report after he was discharged from Rock Creek Care Center. On March 2, 2013, the last methadone listed as filled was prescribed by Respondent for 90 pills.

17. On November 25, 2013, patient A died due to acute methadone toxicity. The patient died 8 months after he was discharged from Rock Creek Care Center. This was his third and last overdose.

18. There were multiple instances when Respondent's signature was on "Continuation of Schedule II Medication Therapy" forms with the prescription either not entered (i.e., left blank) or incompletely filled out. The handwriting of these forms varied considerably and did not appear to have been written by one person or by Respondent consistently. It is not the standard of care for physicians to allow pre-signed prescriptions in the prescribing of controlled substances. It is also not the standard of care for physicians to sign prior to the prescriptions for controlled substances to be filled out appropriately.

19. Respondent committed gross negligence in his care and treatment of patient A, which includes, but is not limited to, the following:

Respondent departed from the standard of care by failing to minimize or avoid the prescribing of opiates in a patient who was at high risk for or had multiple risk factors for opioid-associated overdose. The patient had two recent opioid overdoses with complications, and was on

multiple opioids and methadone. Respondent understood the significance of this patient's high Morphine Equivalent Daily Dosage yet continued to repeatedly prescribe controlled substances to the patient without attempting to reduce it. There were multiple missed opportunities during the 7.5 months that Respondent treated the patient, and multiple visits under his supervision or his face-to-face visit, to collaboratively minimize or avoid prescribing opiates.

20. Respondent's conduct, as described above, constitutes gross negligence in the practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to discipline Respondent's license.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

21. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care and treatment of patient A. The circumstances are as follows:

Patient A

22. Paragraphs 9 through 21 as more particularly alleged above, are hereby incorporated by reference and realleged as if fully set forth herein.

23. Respondent committed acts of repeated negligence in his care and treatment of patient A, which included, but are not limited to, the following:

Respondent departed from the standard of care by failing to write and sign prescriptions for controlled substances in a safe manner by multiple occurrences with multiple missed opportunities to correct the practice of pre-signing.

24. Respondent's conduct, as described above, constitutes repeated acts of negligence in the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to discipline Respondent's license.

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THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

25. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent excessively prescribed controlled substances in his care and treatment of patient A, as more particularly alleged in paragraphs 9 through 19 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 47747, issued to Chandan Deep Singh Cheema, M.D.;

2. Revoking, suspending or denying approval of Chandan Deep Singh Cheema, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Chandan Deep Singh Cheema, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 3, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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